

Blanket Tylenol form



ALABAMA STATE DEPARTMENT OF EDUCATION
SCHOOL MEDICATION PRESCRIBER/PARENT AUTHORIZATION

School Year 25 - 26

STUDENT INFORMATION

Student's Name: _____ School: CHHS

Date of Birth: _____ Age: _____ Grade: _____ Teacher: _____

_____ No known drug allergies _____ Allergies (please list) _____

Over-The-Counter Medication Authorization

Medication Name: Tylenol Dosage: 2 pills Route: oral

Frequency/Time(s) to be given: Every 6 hours as needed. Start Date: 4.22.26 Stop Date: 4.27.26

Reason for taking medication: Headaches, Pain

Potential side effects/contraindications/adverse reactions: Sleepy

Treatment order in the event of adverse reaction: Call Parent

PARENT AUTHORIZATION

I authorize the school Nurse, the registered nurse (RN) or licensed practical nurse (LPN), to administer or to delegate to unlicensed school personnel the task of assisting my child in taking the above medication in accordance with the administrative code practice rules. I understand that additional parent/prescriber signed statements will be necessary if the dosage of medication is changed.

Prescription Medication must be registered with the School Nurse or Trained Medication Assistant. Prescription medication must be properly labeled with student's name, prescriber's name, name of medication, dosage, time intervals, route of administration and the date of drug's expiration when appropriate.

Over the Counter Medication must be presented to the School Nurse or Trained Medication Assistant. OTCs must be in the original, unopened, and sealed container. OTC medication may not be kept for more than 2 weeks without written authorization from an authorized licensed healthcare provider. Local Education Agency Policy for OTC medication must be followed.

Parent's/Guardian's Signature: _____ Date: _____ Phone: _____